THE OLYMPIC REGION

BEHAVIORAL HEALTH REPORT

CLALLAM | JEFFERSON | KITSAP

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Olympic COMMUNITY of HEALTH

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Executive Summary

Behavioral health is an area of high importance and needed support in the Olympic region and across Washington State. Compared with other states, Washington State has a higher prevalence of behavioral health conditions and lower rates of access to care. The Olympic region faces many behavioral health challenges including barriers to transportation, broadband and technology, rural care, workforce, and access to recovery services. The region also has the benefit of caring, dedicated, and talented partners addressing both long-standing and current behavioral health needs.

This report is a step towards better understanding the health of Clallam, Jefferson, and Kitsap Counties, and the sovereign Tribal nations within the region. Many collaborative and innovative projects are in the works across the region. There is much to gain from past and current successes, efforts, and partnerships. Supporting behavioral health needs is a large task to tackle, and together we can foster a region of healthy people and thriving communities.

There are many opportunities for legislators, policy makers, health care providers, community-based organizations, social service agencies, Tribal health centers, and communities to prioritize behavioral health. Olympic Community of Health (OCH) proposes recommendations based off report findings and discussions with community and behavioral health partners. Recommendations include (*see all recommendations on page 23*):

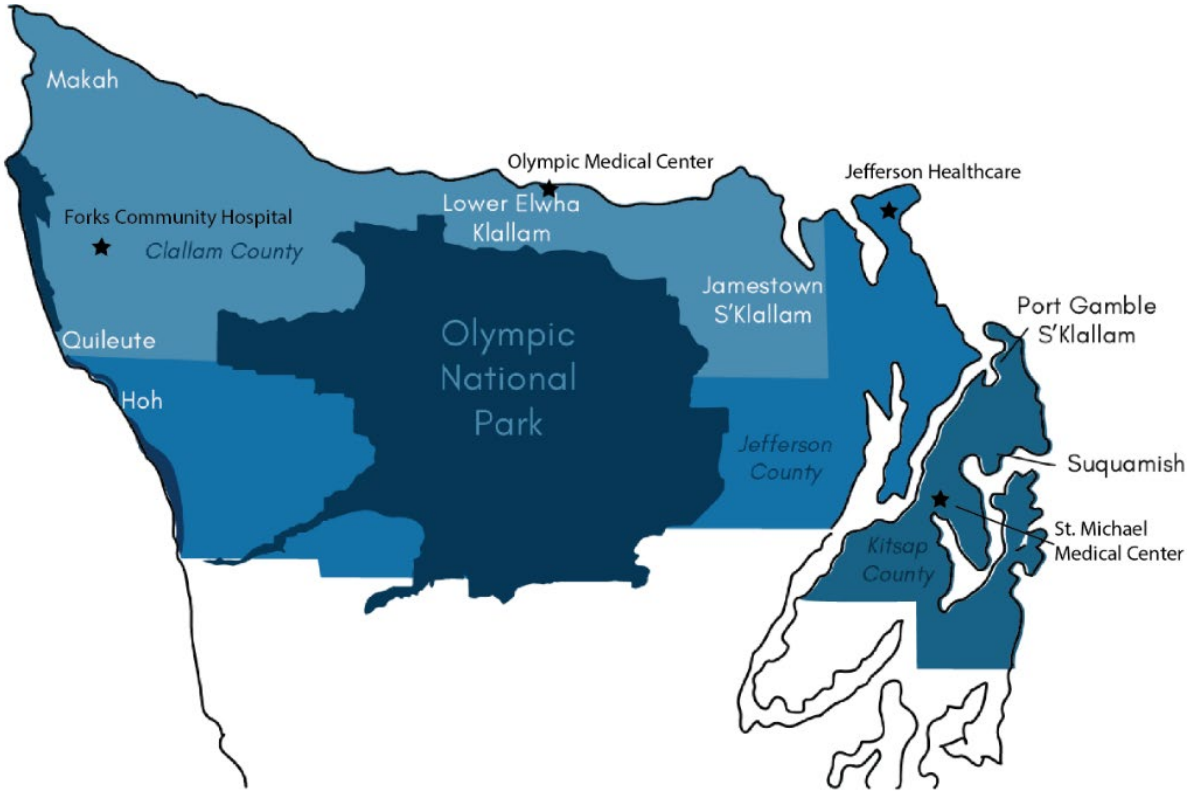
- Advocate for behavioral health reimbursement rates that are based on actual costs and salaries.
- Provide advocacy to increase salaries for behavioral health providers commensurate with their education, training, and the cost-saving benefit their services provide.
- Prioritize innovative and creative transportation solutions to improve access to care across the region.

This report aims to:

1. Provide an overview of the makeup of the Olympic region and unique factors impacting behavioral health.
2. Offer a current snapshot of the Olympic region's behavioral health prevalence.
3. Outline current gaps and challenges faced by the Olympic region.
4. Describe actions the region has taken to support behavioral health needs and highlight creative approaches.
5. Pinpoint specific opportunities and recommendations for future behavioral health support.

Introduction

OCH is an Accountable Community of Health (ACH) in Washington State that serves the Olympic region. OCH brings together partners from a variety of sectors and Tribes to tackle health issues no single sector or Tribe can tackle alone. ACHs are an integral part of the Washington's Medicaid transformation efforts, working to cost, experience, and quality of health care for community members enrolled in Medicaid (officially known as Apple Health in Washington State). Behavioral health is an area of high importance and needed support in the Olympic region. This report provides a summary of the current behavioral health challenges, successes, and opportunities within the Medicaid population of the Olympic region, in hopes that it will guide future decision making and regional next steps. OCH acknowledges that this is not a comprehensive report as it does not capture every aspect that impacts behavioral health in the Olympic region. This report is a step towards better understanding the health of the three-county region. Supporting behavioral health needs is a large task to tackle, and together we can foster a region of healthy people and thriving communities.



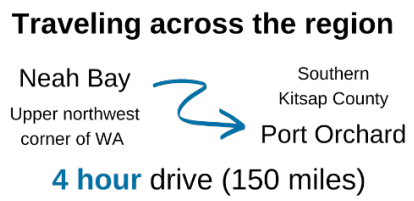
Overview: The Olympic Region

The Olympic region spans Clallam, Jefferson, and Kitsap Counties and includes the seven sovereign nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes.

Clallam and Jefferson counties comprise the largely rural Olympic Peninsula. Port Angeles, the largest city and the seat of Clallam County, has a population of just over 20,000. Forks is the largest town and health care access point on the west end with a population of approximately 3,680 and one critical access hospital [1]. It is approximately a 1-hour journey by car to travel the 24 miles from the Hoh Reservation to the closest health care access point.

Port Townsend, with a population under 10,000, is the seat of Jefferson County [2]. It is the city and home to the only hospital in the county. It is approximately 38 miles and takes a little less than 1 hour to travel from Brinnon in

southern Jefferson County to Port Townsend. Public transportation is severely limited throughout most of the Olympic Peninsula and many locations are only accessible by use of private vehicle.



The Olympic Peninsula is home to the beautiful Olympic National Park. No through access is available in the National Park, elongating travel times around the region. Access from the Olympic Peninsula to Kitsap County is most commonly and conveniently made via the Hood Canal Floating Bridge, which closes daily due to leisure, commercial, and military marine traffic as well as unfavorable weather conditions.

Kitsap County is more suburban with a population of 272,200 and several city centers, in addition to the rural outreaches of Olalla, Seabeck, and Hansville. [3] Kitsap County's commuting population has steadily increased as access to Seattle becomes more convenient through a 30 minute fast-ferry ride. In recent years, public transportation has grown, including the use of some ride-share services. However, these options are still limited compared to larger cities and the most common and convenient transportation is use of private vehicle.

The Olympic region houses four hospitals, one each in Jefferson and Kitsap Counties, and two in Clallam County. Two of the hospitals, Forks Community Hospital (Clallam) and Jefferson Healthcare (Jefferson) are designated as critical access, a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). It is designed to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services available in rural communities. [4] For severe acute health care services, travel out of the region is often necessary. It is common for individuals to be referred and receive specialty care in Kitsap, Pierce, and King Counties. The Olympic region also has two Federally Qualified Health Centers (FQHC), one in Port Angeles (North Olympic Healthcare Network) and the other (Peninsula Community Health Services) with locations in the major city centers of Kitsap County as well as mobile behavioral health clinic services.

Olympic Region Demographics

The Olympic region has a significantly older population when compared to the state average. This trend is important to note, as it effects region-wide service needs. Regionally, 25% of the population is enrolled in Medicare and approximately 20% are enrolled in Medicaid. [5]

Figure 1

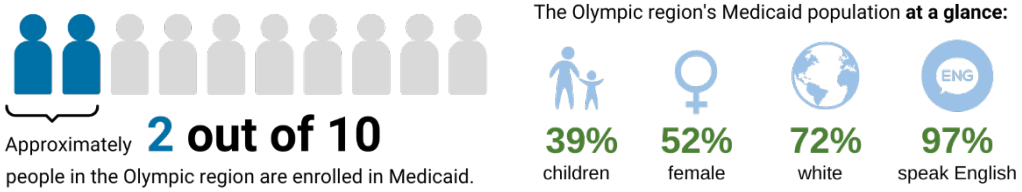


Figure 1 source: Washington Healthcare Authority (2020) [6]

Figure 2	Clallam	Jefferson	Kitsap	WA State
65+ years old	30.0%	38.0%	22.0%	16.0%
Median income	$49,913	$54,471	$71,610	$70,116
Education (four-year college graduation rate)	26.1%	41.8%	32.2%	35.5%

Figure 2 sources: U.S. Census Bureau (2020) [7] and Washington State Office of Financial Management (2019) [8]

Tribal Partners and Indian Health Care Providers

OCH is honored to partner with the seven sovereign Tribal nations in the Olympic region: Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes. Of the seven Tribes, six are Indian Health Care Providers (IHCPs). Each Tribe provides a range of services for their community including culturally relevant behavioral health prevention and wellness programs.

Travel can be a major obstacle for services not provided by the Tribes including urgent and critical care. It takes over an hour to travel from the Makah reservation to the nearest hospital in Forks and nearly two hours to reach Port Angeles for specialty referrals and Level III trauma care. It is common for Tribal members to travel to Bremerton and Seattle, four to five hours one-way by private vehicle from Quileute, Hoh, or Makah to access specialty care.

Military

The Olympic region has a robust military and substantial veteran presence. Kitsap County is home to the large Naval Base Kitsap, the host command for the Pacific Northwest Navy fleet, as well as the Puget Sound Naval Shipyard and Intermediate Maintenance Facility, the Pacific Northwest's largest Naval shore facility and one of Washington state's largest industrial installations. Jefferson county is home to Naval Magazine Indian Island, one of the largest munitions depots and ordnance storage sites. The Coast Guard has a presence in all three counties as well.

A large military presence is naturally reflected by a transient population, with frequent deployments and transfers. The military internally hosts comprehensive medical and social services, with most members and dependents receiving care at military facilities. However, emergency services are accessed through regional hospitals and emergency departments. Additionally, for a variety of reasons, some military members and dependents choose to seek health care and social services from community providers rather than military providers.

Veterans account for 16.8% of the total adult population in Kitsap County and for 15% and 15.7% in Clallam and Jefferson Counties, respectively. [9] Two Veterans Administration (VA) clinics serve eligible veterans in our region: the North Olympic Peninsula Community Based VA Clinic in Port Angeles (Clallam County) and the Silverdale VA Clinic (Kitsap County). Eligible veterans may apply with the VA to receive care from a local community provider who is part of the VA's network. [10]

Behavioral Health: A Current Snapshot

With the makeup of the Olympic region in mind, we can dive a bit deeper into the current behavioral health trends. Mental health and substance use disorders (SUDs) are collectively referred to as behavioral health disorders.

Adults with behavioral health disorders are less likely to care for their chronic medical conditions and more likely to experience worse outcomes of co-occurring chronic diseases compared with patients without behavioral health disorders. [11] They are also more likely to have frequent emergency department (ED) visits.

Nationally, use of the ED for mental health visits has been increasing. A report by the Agency for Healthcare Research and Quality found that the number of ED visits related to behavioral health disorders increased more than 44 percent between 2006 and 2014, with suicidal ideation visits growing by nearly 415 percent. [12] Similarly, behavioral health is among the top reasons for hospital inpatient stays among adults 18-44 years of age. [13]

Meeting community behavioral health needs is a long-standing priority for the Olympic region. Behavioral health progress is evident in myriad creative strategies that have been implemented in the Olympic region, including:

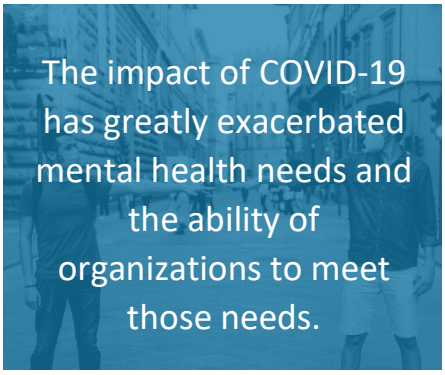
- **Kitsap**
  Peninsula Community Health Services' community health workers are innovatively partnering with local organizations including the county jail, Salvation Army, and WorkSource to better understand and provide for community needs.
- **Clallam**
  The Port Angeles Fire Department implemented a community-paramedicine program which partners with agencies including Peninsula Behavioral Health and Olympic Peninsula Community Clinic ("the free clinic") to connect clients who are frequent emergency department users with the services they need. The result is a 50% reduction in emergency department visits among individuals assisted by the community paramedic.
- **Jefferson**
  The Sheriff's department has secured funding to hire a navigator who will assist individuals with unmet behavioral health needs to access services and care.
- **Community-based interventions** to support well-being and prevent behavioral health problems are evident in the work of Kitsap Strong and the Clallam Resiliency Project. These non-profits work towards upstream solutions, providing education on N.E.A.R. Science (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) and trauma-informed practices for health care providers, schools, faith-based organizations, and other community groups.

A current behavioral health focus is integration of services. Integration can be achieved through a variety of approaches. One approach is to increase the range of services a practice offers. For instance, for primary care practices to onboard behavioral health staff, and vice-versa. Another effective option is to create closer collaboration and referral networks between and among organizations. Examples of strategies to achieve integration of services includes hiring clinical social workers to facilitate care connection for complex medical patients, creating multiagency care coordination teams such as Clallam Care Connection (see page 23), and using telehealth services to provide psychiatric evaluations, behavioral health therapy, and medication management. Behavioral health practices face unique challenges when it comes to integrating physical health, largely due to reimbursement barriers.

Across the region, behavioral health and physical health providers have made substantial progress in collaborating. Notably, the Three-county Coordinated Opioid Response Project (3CCORP) provides collaboration opportunities for behavioral health and physical health partners to align strategies and goals around opioid use disorder.

COVID-19

The impact of COVID-19 has greatly exacerbated mental health needs and the ability of organizations to meet those needs. [14] Behavioral health providers described losing clients during the rapid closing of services in March 2020 as Washington's "Stay Home, Stay Healthy" COVID-19 order was instituted. Inpatient and outpatient practices abruptly limited or halted in-person treatment while scrambling to implement distancing and sanitation protocols and to develop telehealth capacity including securing equipment, writing telehealth policies, and teaching staff and clients how to use the equipment and digital platforms (such as Zoom and Doxy.me). At practices which continued seeing patients in person, employees navigated fear of COVID-19 exposure as they initiated new safety protocols such as wearing a mask and other personal



protective equipment (PPE), all while responding to personal and family needs as schools and workplaces were closed. [15] Initially, Medicaid and Medicare reimbursement restrictions on telehealth and audio-only telehealth prevented behavioral health providers from being able to use remote modalities while staying financially afloat. Reimbursement policy changes at the federal and state level enabled behavioral health practices to provide remote services for their clients during the pandemic. [16]

While some behavioral health clients successfully transitioned to remote care, not all clients are able to access remote services due to technological capacity, such as limited broadband access, and personal comfort level using digital platforms such as Zoom. Washington State Health Care Authority supported access to telehealth by providing Zoom licenses for behavioral health providers and loaning cell phones and laptops to Medicaid clients. They also worked with managed care organizations (MCOs) to ensure rapid resolution of denied telehealth payments as new billing codes were implemented. These actions were a lifeline for cash-strapped behavioral health providers and their clients.

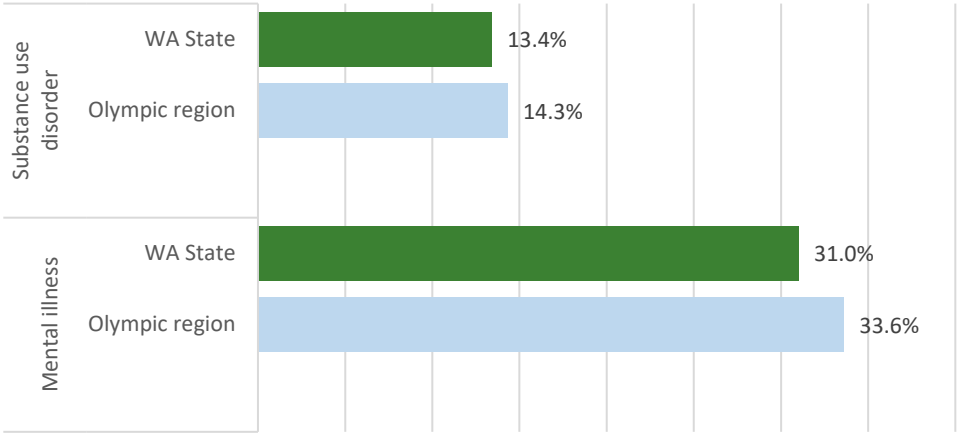
Prevalence of Behavioral Health Conditions

The prevalence of behavioral health conditions in the three-county region is defined as the proportion of the Olympic region's population who experiences behavioral health conditions in a given time period (including both mental health conditions and substance-use disorder). By diving into the prevalence of adult mental health, youth mental health, emergency utilization, self-inflicted harm, and treatment penetration, a broader picture of the regional behavioral health needs emerges.

Compared with other states, Washington State has a higher prevalence of behavioral health conditions and lower rates of access to care, ranking 37th (out of 51 states) for adults and 35th for youth in 2021. [17] The 2021 rankings reflect substantial improvement over 2020 when Washington State ranked 45th (out of 51) for adults and 43rd for youth on higher prevalence and lower rate of access. [18]

The prevalence of mental illness and substance use disorder among Medicaid enrolled adults between the ages of 18 and 64 in the Olympic region is higher than the statewide prevalence (Figure 3).

Figure 3: Prevalence of any mental illness and substance use disorder among adults 18-64 years of age and older on Medicaid (2019)

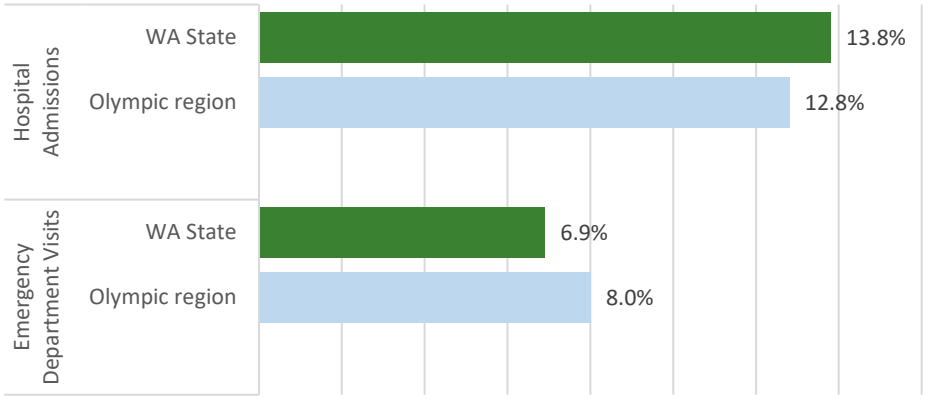


Source: Washington State Healthcare Authority (2020) [19]

Emergency Department and Hospital Inpatient Behavioral Health Needs

In 2019, Medicaid enrollees within the Olympic region demonstrated a lower percentage of hospital inpatient admissions among behavioral health related diagnoses compared to Washington state, accounting for 13.8% of hospital admissions in the region. In contrast, Medicaid enrollees in the Olympic region utilized the emergency department for behavioral health related needs at a higher rate compared to Washington State (Figure 4).

Figure 4: Medicaid enrollee ED utilization with behavioral health diagnosis, all ages (2019)



Source: Washington State Healthcare Authority (2020) [20]

Suicide and Self-Inflicted Injury

In 2020, the Olympic region experienced 735 emergency department (ED) visits related to suicide and self-inflicted injury. Kitsap County accounted for 70% of those visits (Figure 5), followed by Clallam County with 23%, and Jefferson County with 7%. Clallam County experienced the highest incidence rate of suicide and self-inflicted injury visits to the emergency department in the region with 221 visits per 100,000 residents (Figure 6) in 2020. These visits included any individual that presented in an ED in the Olympic region for suicide and self-inflicted injury regardless of insurance status and geographic area of residence.

Figure 5: Percentage of ED visits by County for suicide or self-inflicted injury in the Olympic region (2020)

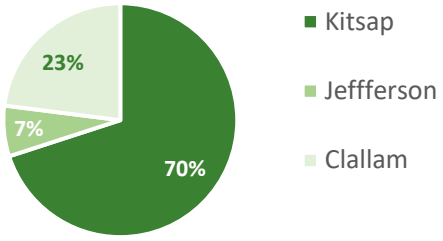
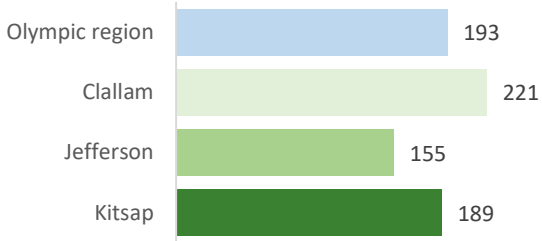


Figure 6: Incidence Rate of Suicide and Self-Inflicted Injury Visits to the Emergency Department per 100,000 Residents by County (2020)



Figures 5 and 6 source: National Syndromic Surveillance Program *(2020)* [21]

By Age

Of ED visits related to suicide and self-inflicted injuries across the three-county region, 51% were under the age of 29. The average rate across all age groups during this time period was 193 visits per 100,000 residents in 2020. The rate of visits for children under the age of nine were suppressed due to small numbers. Rates for individuals between 10 and 29 years of age were over two times the average rate across all age groups (Figure 7).

By Gender

In the Olympic region, females accounted for 53% of ED visits related to suicide and self-inflicted injuries, while males accounted for 47%. Females visited the ED at a rate higher than average for the region at 206 visits per 100,000. (Figure 8*)*.

Figure 7: Incidence rate of suicide and self-inflicted ED visits per 100,000 by age group in the Olympic region (2020)

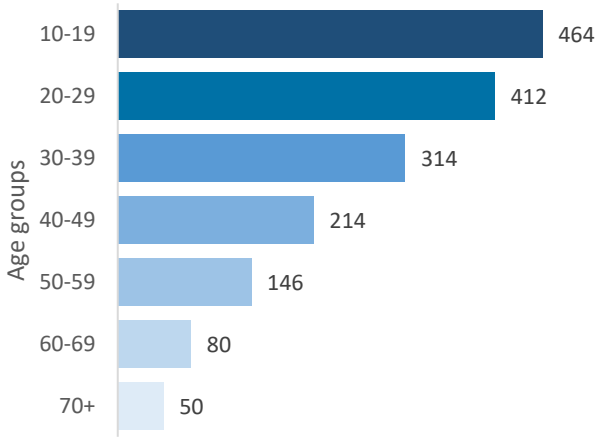
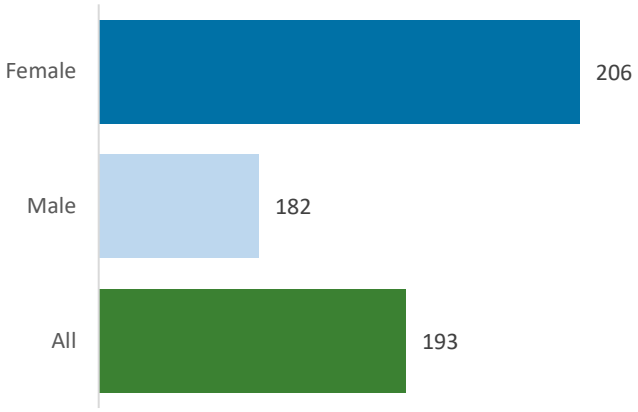


Figure 8: Incidence Rate of Suicide and Self-Inflicted injury ED visits per 100,000 by Gender in the Olympic Region (2020)



Note: Rate for ages 0-9 suppressed due to low number of visits

Figures 7 and 8 source: National Syndromic Surveillance Program *(2020)* [22]

Behavioral Health Treatment

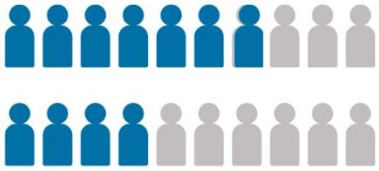
Mental Health Treatment Penetration

Approximately **1 in 2** adults on Medicaid (in the Olympic region) received the **mental health care** they needed.

In the Olympic region, only 53% of adult Medicaid enrollees (age 18-64) and 66% of youth Medicaid enrollees (age 6-17) with a mental health service need identified within the past two years received at least one qualifying service during 2019. While these numbers are not substantially different than the state's mental health treatment penetration rate, there is room for improvement. [23]

Approximately **7 out of 10** **youth** on Medicaid (in the Olympic region) received the **mental health care** they needed.

Approximately **4 out of 10** **youth** on Medicaid (in the Olympic region) received the **SUD treatment** they needed.



Substance Use Disorder (SUD) Treatment Penetration

In the Olympic region, 46% of adult Medicaid enrollees (age 18-64) with a SUD treatment need identified within the past two years received at least one qualifying service during 2019. Among youth Medicaid beneficiaries (age 12-17), 35% received at least one qualifying treatment. SUD treatment penetration among adults varies by county. Clallam County has strongest treatment penetration at 46%, followed by Jefferson County at 35% and Kitsap County at 31% [24]

Opioid Use Disorder (OUD) Treatment Penetration

Approximately **1 in 2** adults on Medicaid (in the Olympic region) received the **OUD treatment** they needed.

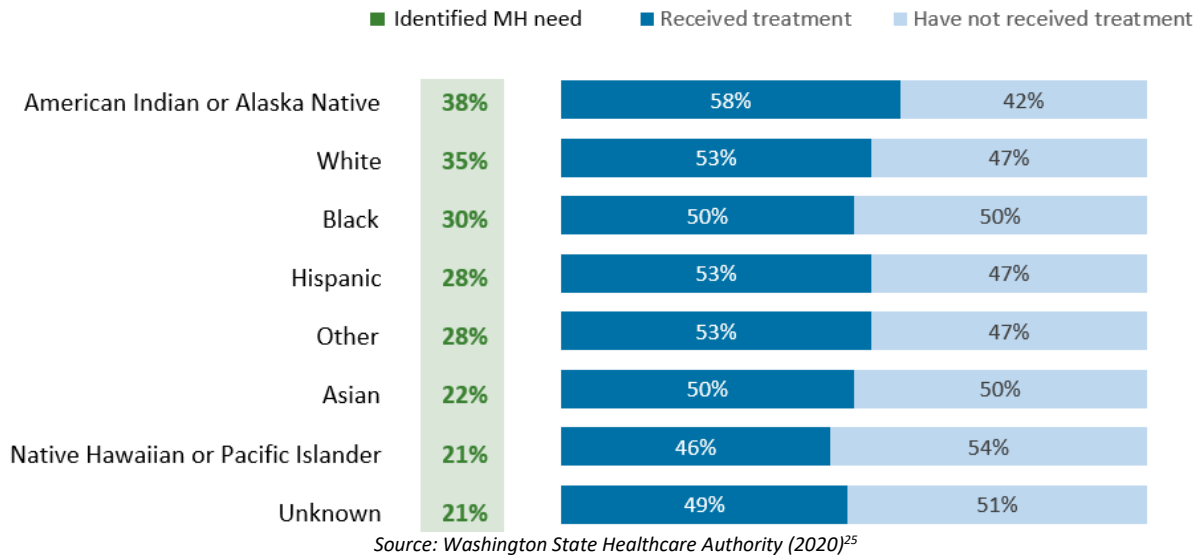
In the Olympic region, 52.7% of adult Medicaid enrollees (18-64) with an OUD treatment need identified within the past two years received medication-assisted treatment (MAT) or medication-only treatment for opioid use disorder during 2019. This compares with state OUD treatment penetration rate of 58.6%. This reflects an improvement over time from 34.8% measured in 2017. [25]

Behavioral Health Need and Rate of Treatment by Race & Ethnicity

Behavioral health needs vary by race and ethnicity in the Olympic region. Among Medicaid enrollees (ages 18-64), 38% of American Indian/Alaska Native (AI/AN) have an identified mental health need compared with 21% of Native Hawaiian or Pacific Islander. Treatment rate disparities exist between races and ethnicities for those with an identified mental health need. Among those identified as having a mental health need, 46% of Native Hawaiian or Pacific Islander Medicaid enrollees have received treatment compared to 58% of AI/AN Medicaid enrollees. Medicaid enrollees who are Asian, Black, 'Unknown' race, or Native Hawaiian and Pacific Islander are less likely to receive needed behavioral treatment than AI/AN, Other, White, and Hispanic. Overall, less than 53% of those identified with a mental health need have received treatment (Figure 9).

The Olympic region has improved opioid use disorder treatment penetration from 34.8% in 2017 to 52.7% in 2019.

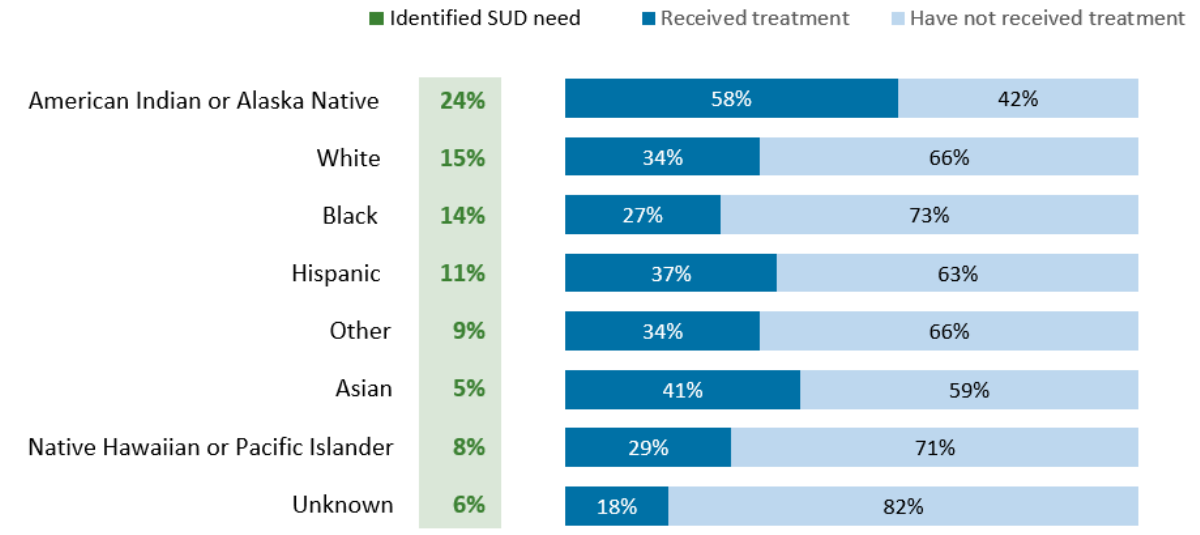
Figure 9: Identified mental health (MH) need and treatment rate among Olympic region adult Medicaid enrollees, by race/ethnicity (2019)



Source: Washington State Healthcare Authority (2020)[25]

Substance use need among adult Medicaid enrollees (ages 18-64) varies by race and ethnicity as well. As shown in Figure 10, AI/AN experience the highest rate of identified substance use need at 24% of Medicaid enrollees. The AI/AN population in the Olympic region also experiences the highest rate of treatment at 58%. Across all races, 36% of Medicaid enrollees with an identified substance use disorder treatment need in the Olympic region are receiving treatment.

Figure 10: Identified substance use disorder (SUD) need and treatment rate among Olympic region adult Medicaid enrollees, by race/ethnicity (2019)



Source: Washington State Healthcare Authority (2020) [26]

Behavioral Health Workforce

Improving behavioral health care services depends in part on ensuring that people have access to a behavioral health provider. Each county in the Olympic region is designated as a Mental Health Professional Shortage Area. [27] Shortages are calculated as the number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, advanced practice nurses specializing in mental health care as well as providers that treat alcohol and other drug abuse per 100,000 population. Most of Washington State is experiencing mental health professional shortages. Overall, the I-5 corridor is more successful in recruiting and retaining mental health professionals than the more rural counties as shown in Figure 11.

Figure 11: Mental health professional shortage areas by county (2020)

	# Mental Health Providers	Ratio to Population
WA State		270:1
Clallam County	256	300:1
Jefferson County	128	250:1
Kitsap County	887	300:1

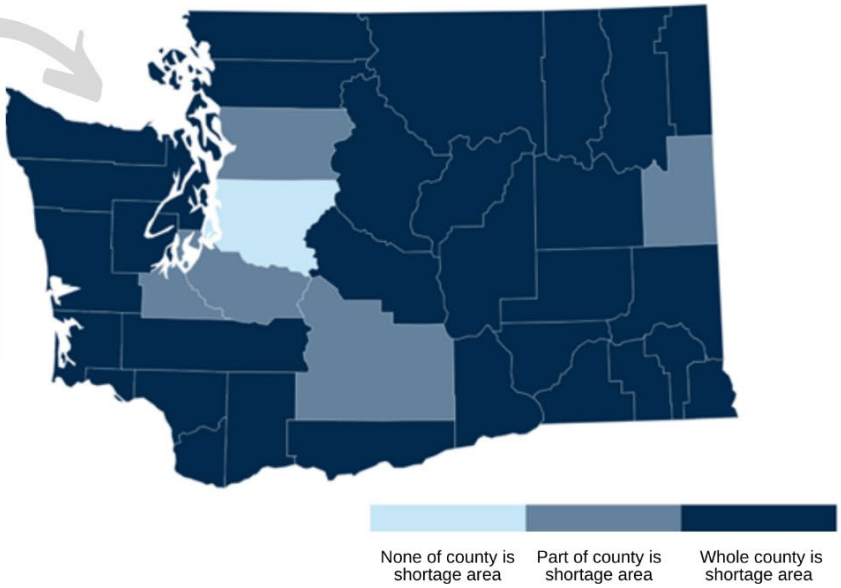


Figure 11 sources:
County Health Rankings & Roadmaps (2020) [28] and Rural Health Information Hub (2020) [29]

In 2017, Washington State conducted a Behavioral Workforce Assessment. The Assessment identified twenty-four categories of occupations credentialed for providing behavioral health services in Washington. The assessment identified that the Olympic region has an aging workforce. The mean age of practitioners is greater than 50 years of age. [30] The implications of this trend will be felt by the region in the coming years, as practitioners retire.

Salary

According to local behavioral health care professionals, Wendy Sisk (Peninsula Behavioral Health) and Jim Novelli (Discovery Behavioral Healthcare), salary wages for local behavioral health staff positions have not historically been shared due to competition for hiring (personal communications, January, 2021). This is slowly changing as agencies begin posting salary ranges for the current openings listed on their websites.

National data show that salaries vary, with licensed clinical and medical providers such as psychiatrists and psychiatric nurse practitioners receiving salaries that are significantly higher than salaries for non-licensed behavioral health workers. A national average for substance use, behavioral disorder, and mental health counselor salary is $52,000.

Source: U.S. Bureau of Labor Statistics (2020) [31]

Local behavioral health agencies that were willing to share staff salary ranges for this report indicated that salaries in the Olympic region trend lower, especially among the community mental health agencies which primarily serve Medicaid enrollees. Jim Novelli, Executive Director for Discovery Behavioral Healthcare explains,

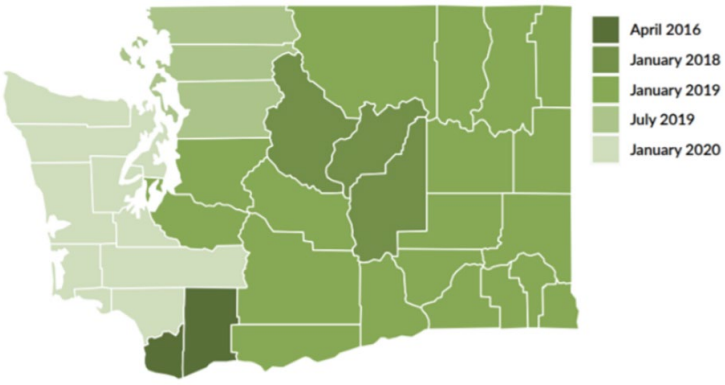
> *"It's a historical issue with community mental health, the rate of pay is significantly lower than those offered by a FQHC or hospital setting due to Medicaid rates being lower than other reimbursement forms. The proposed upcoming Medicaid rate increase of 4.5% isn't sufficient to reach parity with other payers. As a primary Medicaid provider our first priority is Medicaid clients. We don't turn them away or limit the number of Medicaid clients like other places may do. We also struggle to serve Medicare because only licensed clinical social workers are eligible to bill Medicare. We are unable to match salaries offered by hospital systems or other healthcare clinics."* (personal communication, January 14, 2021).

An additional, ongoing challenge to workforce recruitment is the shortage of affordable housing for potential hires wishing to move into the region poses. In Kitsap, average rental rates have increased by 60% over the past ten years, with a 2019 vacancy rate of 4%, lower than a "healthy" vacancy rate of 6 - 8%. [32] Looking at fair market value for rentals, each county in the region rates as "very high" compared to the national average and more expensive than most of the state of Washington. [33]

Integrated Managed Care

Mandated by the state, integrated managed care (IMC) aims to coordinate physical health, mental health, and substance use disorder treatment services to help provide "whole-person" care under one health plan. Most Medicaid clients have managed care, which means Washington State Medicaid pays health plans (Managed Care Organizations) a monthly premium for preventive, primary, specialty, and other health services coverage. Some Medicaid clients remain on a fee-for-service (FFS) arrangement, including many Tribal members.

Figure 13: IMC regions by implementation date



Source: Center for Health Systems Effectiveness (2020) [34]

Transitioning to Integrated Managed Care in the Olympic Region

The Olympic region fully transitioned to IMC on January 1, 2020 (Figure 13). The transition to IMC impacted all behavioral health providers in the region as well as physical health providers in Clallam County, the only county in Washington State that did not previously have managed care for physical health. While the region had ample notice regarding the transition, no funds were allocated to support system improvements such as electronic health record (EHR) changes, technical assistance to providers to understand the changes, and community education. Providers spent many hours and financial resources preparing for and implementing the transition.

The unforeseen COVID-19 pandemic collided with the region's transition to IMC and augmented the IMC transition challenges for providers and clients:

- ***Provider payments –*** Many behavioral health providers experienced unwarranted claim denials and rejections due to new billing codes.
- ***Reduced funding for non-Medicaid services*** – Services for individuals who are uninsured and underinsured decreased dramatically in 2020 causing some to turn to emergency departments for care and many to go without needed behavioral health care entirely.
- ***Launch of telehealth services*** – While the launch of telehealth services is greatly needed, especially in a rural area like the Olympic region, it was not planned for. The region lacks widespread broadband internet access, and many behavioral health clients do not have access to cell phones or computers.

The Olympic region's transition to Integrated Managed Care collided with the COVID-19 pandemic, causing a range of additional challenges and burdens for providers and clients.

Role of the Behavioral Health Administrative Service Organization

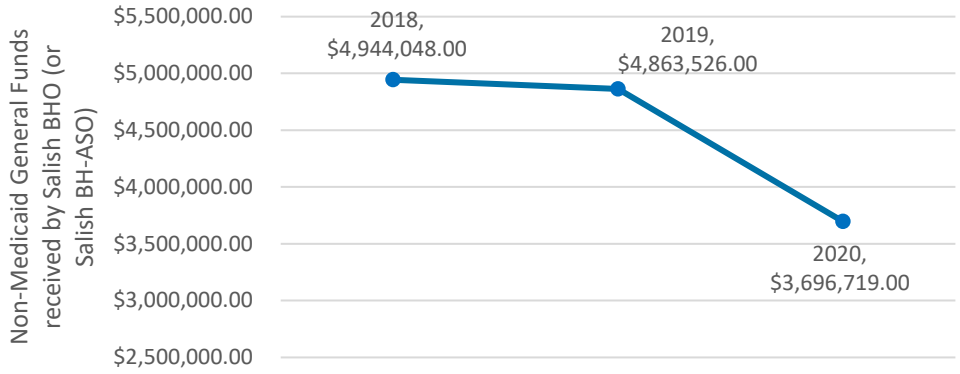
Prior to the launch of IMC in 2020, Medicaid enrollees' low intensity mental health service benefits were managed by Washington State Medicaid MCOs. Low intensity mental health services are defined as services provided by primary care offices and by private practitioners and therapists. Higher intensity mental health services and all substance use treatment were behavioral health benefits managed by regional Behavioral Health Organizations (BHOs). [35]

With the transition to IMC, the role of the BHO dissolved. The responsibility for behavioral health benefits management, low to high intensity services, was transitioned to Medicaid MCOs. Under IMC, MCOs manage both physical and behavioral health benefits, referred to as whole-person care, for Medicaid Managed Care enrollees. The MCOs currently providing managed care benefits in the Salish region are: Amerigroup Washington, Molina Healthcare of Washington, and UnitedHealthcare Community Plan. [36]

Another system change that was implemented in January 2020 was the creation of a Behavioral Health Administrative Services Organization (BH-ASO). In the Olympic region, this is the Salish BH-ASO (SBH-ASO). The SBH-ASO is responsible for managing the Regional Crisis System for all individuals regardless of funding or insurance status. The SBH-ASO contracts with a network of local behavioral health agencies who are licensed to provide 24/7 crisis services. Crisis services include toll-free crisis line services, mobile crisis outreach, and involuntary treatment investigations. The SBH-ASO is also responsible for the cost of involuntary treatment (psychiatric inpatient and secure withdrawal management) for individuals without Medicaid or other resources.

If financial resources remain after providing for the Regional Crisis System and involuntary treatment, the SBH-ASO may also provide for limited non-crisis behavioral health services for non-Medicaid individuals, such as outpatient treatment. However, with the reduction in non-Medicaid funding that occurred with the transition to IMC, very limited funding is available to provide for non-crisis services to non-Medicaid individuals. Overall, non-Medicaid funding from the state's General Fund has decreased from 2018 through 2020 (Figure 14).

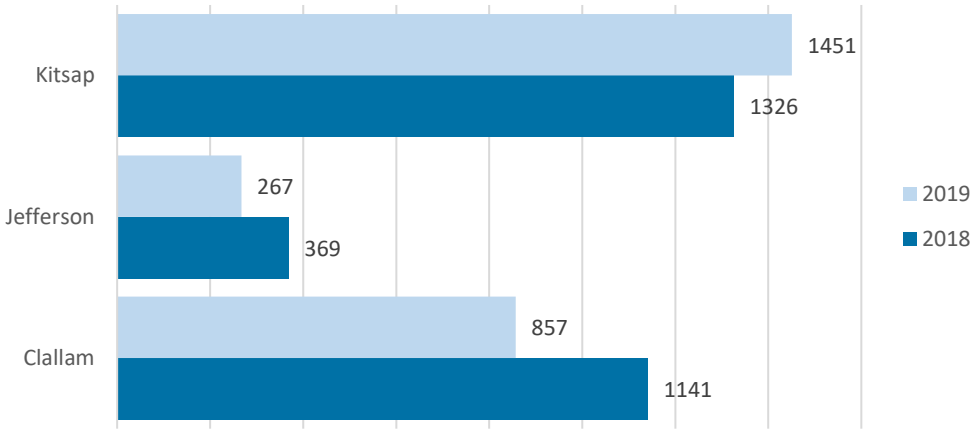
Figure 14: Non-Medicaid General Funds received in 2018-2020



Source: Salish Behavioral Health Administrative Services Organization (2020) [37]

The SBH-ASO provides for behavioral health crisis services to everyone within the region, regardless of insurance coverage. During 2018 and 2019, the most recent years for which data is available, the SBHO's Crisis Provider Network provided a total of 4,845 and 4,594 crisis services, respectively. [38] These services are broken down by county in Figure 15.

Figure 15: Crisis Services provided by Salish Behavioral Health Organization by County in 2018-2019

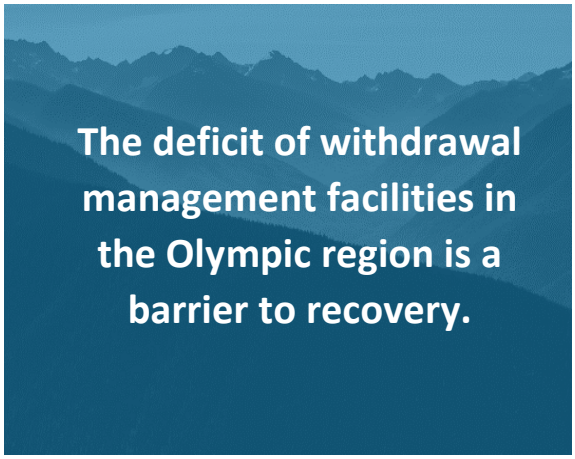


Source: Salish Behavioral Health Administrative Services Organization (2020)

Gaps & Challenges

There are many opportunities for improvement in prevention, treatment, and access to behavioral health care in the Olympic region. Here we focus on areas that have been raised by partners across our region.

Substance Use Withdrawal Management Facilities



Medically supported withdrawal management is often recommended for individuals with severe addiction who are at risk of seizures, respiratory failure, or other fatal side effects caused by acute withdrawal. Medical withdrawal management provides inpatient care so that the individual may be continuously monitored and supported by medical professionals. There are currently **zero medically assisted withdrawal management facilities** operating in Olympic region**.** Individuals requiring medically assisted withdrawal management services are referred to high-demand facilities in Tacoma, Chehalis, Lacey, Seattle, and other distant locations. Even when a referral is secured and a bed space is available, lack of transportation to these locations is a barrier to accessing care.

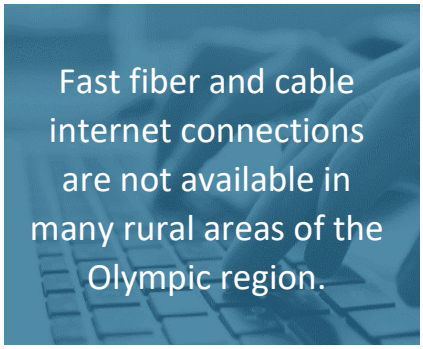
Residential withdrawal management (formerly known as "subacute detoxification") provides short-term non-medical inpatient support services for clients experiencing mild to moderate withdrawal symptoms. It is designed to monitor vitals, provide medication reminders, and support the client through the withdrawal process. To be accepted for this service, individuals must meet agency-established limits based upon screening tools that determine if an individual is not at medical risk and is past the worst symptoms of withdrawal (Figure 16). [39]

Figure 16: Residential withdrawal management facilities currently operating in the Olympic region

Kitsap County	Kitsap Recovery Center	**6 male & 3 female beds**
Kitsap County	Olalla Recovery Centers	**2 male & 1 female beds**
Jefferson County	N/A	**0 beds**
Clallam County	N/A - *Specialty Services closed their withdrawal management unit in March 2020*	**0 beds**

Broadband Internet Access

Limited access to broadband internet is a barrier to utilizing telehealth and telemedicine diagnosis and treatment services. Broadband internet, as defined by the Federal Communications Commission (FCC), has speeds of at least 25 megabytes per second (Mbps) download and at least 3 Mbps upload. [40] Limited access is also a barrier for youth and adults struggling to keep up with remote school and work requirements.



Broadband internet access varies geographically with lower access in rural and remote geographic areas; 3% of Kitsap residents do not have access to broadband compared with 15% and 17% in Clallam and Jefferson, respectively. [41] Fast fiber and cable internet connections are not available in many rural areas of the Olympic region. Current options in these areas include using phone lines (which can be slow and ineffective for the live audio and visual streaming required by telemedicine) and satellite connections (which are expensive). In Forks, there are three providers offering residential internet service, of which only one offers wired connection (DSL via phone lines). In comparison, residents of Bremerton may select from five residential internet providers, four of which offer wired connections (high-speed fiber and cable). [42]

Rates and Policies

Access to behavioral health care is impacted by reimbursement rates and policies. Here we describe two examples that have negatively impacted access to health care services: Medicare restrictions on SUD inpatient treatment and low or no reimbursement rates for telehealth.

Medicare coverage of SUD inpatient treatment is subject to restrictions which make it difficult for clients to access services. Medicare reimbursement for inpatient treatment is limited to hospital-based treatment facilities. There are no such facilities in the Olympic region and there is a high demand for openings in out-of-region hospital-based treatment facilities. Previously, the BHO provided funding to support inpatient treatment for Medicare clients at non-hospital facilities; that assistance has diminished with the decreased funding now provided to the BH-ASO (personal communication, Three-county Coordinated Opioid Response Project Treatment workgroup, January 20, 2021).

Before COVID-19, FQHCs and Rural Health Centers (RHCs) were not permitted to bill Medicare as a distant site for telehealth. While it is temporarily permitted, under the COVID-19 CARES Act, it "unfortunately still reimburses relatively poorly," at about 30% of what would be reimbursed by Medicare for an in-person visit (M. Maxwell, personal communication, March 21, 2020). For other non-FQHC/RHC health care practices, telehealth was permitted prior to COVID-19 and billed at a lower rate than in-person care.

Early in the pandemic, Governor Inslee's Proclamation 20-29 recognized the importance of telehealth options and specifically authorized such visits to be reimbursed at the same payment as an in-person encounter. Unlike the situation with Medicare, this removed any financial penalty barriers to providing telehealth services for Medicaid clients. Similarly, the Governor mandated that, during the pandemic, the commercial insurance plans must reimburse telehealth at the same rate they would reimburse a face-to-face visit. [43] These allowances are characterized as temporary for the duration of the pandemic emergency. Should encounter-parity be removed post-pandemic, there will once again be a barrier to providing telehealth.

Privacy Regulations:
HIPAA and 42 CFR Part 2

In 1975 Congress passed legislation known as 42 CFR Part 2 which guarantees the confidentiality of information for individuals seeking treatment or with a diagnosis of substance use disorder at a federally assisted program. The statute requires that a patient must give specific written consent before information related to their SUD diagnosis or treatment plan is shared with non-addiction providers. The intent behind the law was to safeguard alcohol and drug patient information from use by law enforcement as well as to prevent housing and employment discrimination. [44]

No other chronic or acute diagnosis has the same shroud of protection as substance use disorder. Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which permits disclosure of client records without consent for the purpose of case management and care coordination. The only mental health record disclosure given special attention under HIPAA are psychotherapy notes which are recorded separately and are not included in the medical record. [45]

Because 42 CFR Part 2 requires an individual's consent for almost every instance of disclosure, it is an obstacle to timely sharing of information and blocks providers from easily and effectively coordinating care. The result is a fragmented system of care which frustrates efforts to integrate behavioral and physical health for individuals experiencing SUD, with potential for duplication and gaps in care which increase possibility for patient harm. [46] An additional unintended consequence of 42 CFR Part is that behavioral health providers face additional barriers to participating in electronic health information exchanges. [47]

Recovery Housing

Recovery houses are safe, healthy, substance-free living environments that support individuals who are in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. [48] There currently is no state or local data source identifying existing recovery residences in Washington State.

In 2019 Washington State HB1529 legislated a registry of certified recovery housing be established and maintained. As part of that process, OCH's Three-county Coordinated Opioid Response Project (3CCORP) treatment workgroup began collaborating with the Fletcher Group and surveyed the region to identify existing recovery housing. Initial findings from the regional survey indicate that the vast majority of recovery housing available in the Olympic region are peer-run Oxford Houses [49]. Regionally, Oxford Houses accommodate seven to ten individuals with better access to housing for men than for women and families available. Access to recovery housing in the Olympic region varies by county, with 9 Oxford Houses (75 beds) in Clallam County, 26 (224 beds) in Kitsap County, and none in Jefferson County. [50]

1/10th Citizens Advisory Committees

The Hargrove bill was passed by the Washington State legislature in 2005. It allows counties to pass a 1/10 (one tenth) of 1% sales tax for mental health, substance use treatment and to support court treatment programs. The bill was passed in recognition that behavioral health needs exceeded available funding. Each county administers their own 1/10th of 1% dollars. [51] Jefferson County Commissioner Brotherton reported that many 2020 applicants returned with funding requests in 2021. The county allocated $493,123 to 15 programs including transitional housing projects by Olympic Community Action Programs (OlyCAP) and Discovery Behavioral Healthcare and therapeutic housing support by Jefferson County's Juvenile & Family Court (personal communication, January 14, 2021).

Determinants of Health

It is estimated that about 20% of what creates health is related to access and quality of health care, including behavioral health care. The remaining 80% is shaped by the conditions in which people are born, live, grow, work, and age. These conditions shape health in a way that is beyond the reach of the health system and are referred to as the determinants of health (DoH). DoH can shape a person's health positively or negatively. Addressing social needs is an upstream solution that may prevent behavioral health needs before they begin.

Figure 17: Determinants of Health

Economic Stability	Education	Social and community context	Neighborhood and physical environment	Health and health care
Employment	Early childhood education & development	Civic participation	Violence and safety	Access and coverage to health care
Income	Education level	Discrimination	Housing quality	Quality of care
Debt	High school graduation	Incarceration	Transportation	Provider cultural competency
Food security	Language and literacy	Social cohesion	Walkability and parks	Health literacy
Housing	Vocational training	Support systems	Environmental pollutants	
		Stress	Air and water quality	

Figure 17 source: Olympic Community of Health (2020)[50]

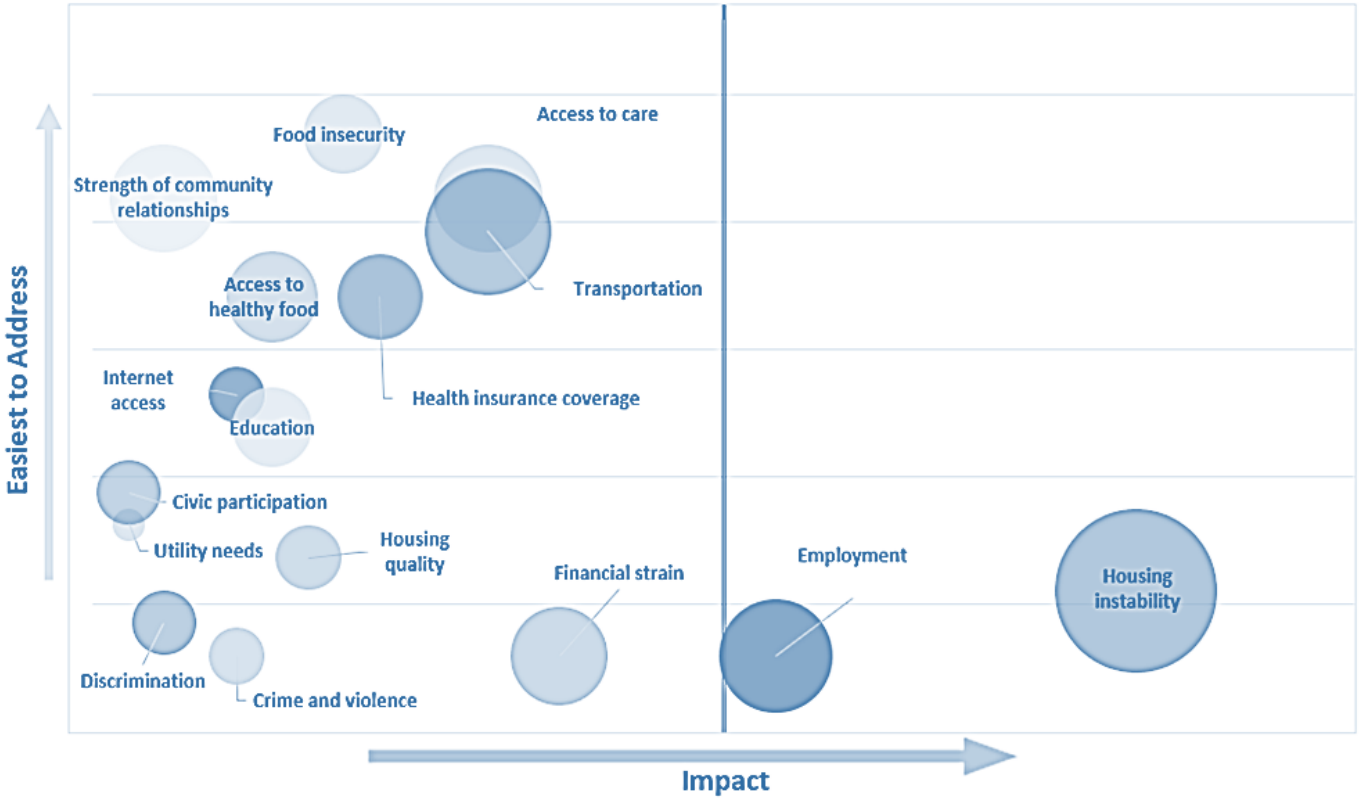
The COVID-19 pandemic is exacerbating social risk factors for millions, including loss of employment, subsequent health coverage loss, worsening food insecurity, and increasing housing instability. Many marginalized communities have been impacted disproportionately.

Figure 18 provides a visual of the Olympic region's priorities regarding determinants of health as determined by a regional survey conducted by OCH in May, 2020. Housing instability and employment were identified as social risk factors that would have both great impact and benefit from a regional response.

OCH is committed to addressing local determinants of health by taking the following next steps:

- Complete a full inventory of regional determinants of health work with a goal of maximizing current resources and work, increasing collaboration, and identifying funding gaps.
- Host a region-wide housing summit including a full data overview, highlighting successes, promising models, and providing space for collaborative problem solving.
- Encourage current Medicaid Transformation Project partners to advance community-clinical linkages, strengthening relationships across organizations, Tribes, and communities.
- Identify and coordinate funding opportunities to support local efforts addressing determinants of health.

Figure 18: Determinants of health priorities regarding ease, potential impact, and benefit from regional response (circle size).



Source: Olympic Community of Health (2020) [52]

Olympic Region Creativity & Successes

Local Approaches

The Olympic region has many communities, organizations, and Tribes working together to support the behavioral health needs across the region. OCH has seen many successes related to improving individual and population health across the region. Below are just a few examples of innovative projects by OCH partners.

Resiliency and Trauma-Informed Care Related Projects

Becoming a trauma-informed organization | Olympic Area Agency on Aging's (O3A)
O3A's Program Manager is a certified trauma-informed care trainer and is equipped with the experience and tools necessary to lead trauma-informed care workshops for all O3A branches. During COVID-19, O3A adapted their trauma-informed care training to a digital platform, allowing them to cater the training to a remote workforce and engage more staff than initially planned.

Resilience video project | Clallam Resilience Project
Clallam Resilience Project's Take Care and Be Well Tiny Video Series is a collection of short videos (2-5 min) highlighting resilience centered skills. The videos feature representatives from Jefferson County Health Department, Quillayute Valley School District, United Way of Clallam County, First Step Family Support Center, Nurturing Families LLC, Olympic

Community of Health, Clallam County Commissioner, Clallam County Health and Human Services, and more.

Tribal wellness kits | The Quileute Tribe
The Quileute Tribe provides monthly wellness kits to every household in the reservation. The kits have had an incredible impact on the community, providing opportunities for creative expression, safe community connections, and raising awareness of local services available through the Quileute Health Center.

Substance-Use Disorder/ Opioid-Use Disorder Related Projects

Syringe exchange | Peninsula Community Health Services (PCHS)
PCHS is now providing syringe exchange at five of their pharmacies. Kitsap Public Health District is partnering with PCHS to transition the public health district's syringe exchange services to a network of fixed-location health care facilities while the health district continues to provide a mobile syringe exchange program in rural areas of Kitsap County. PCHS provides medication assisted treatment and this change will increase linkage between needle exchange and treatment services.

Community paramedicine program | Port Angeles Fire Department
Port Angeles Fire Department hired a community paramedic who works with the Port Angeles Police Department social worker to remove barriers to recovery. The community paramedic and social worker remove barriers by identifying high risk individuals, coordinating care, providing transportation, and conducting outreach with the homeless community via homeless shelters and visits to homeless camps. In just six months, the Community Paramedicine program saw a 50% decrease in EMS calls and transports to the Emergency Room after initial contact with the Community Paramedic. The concept of community paramedicine has spread, Jefferson Police Department is in process of creating policies and procedures to support a social worker.

Community Health Improvement Program (CHIP) | Jefferson County
Jefferson County CHIP works to strengthen and expand Substance Use Disorder and Opioid Use Disorder prevention, treatment and recovery services. They conducted a needs assessment addressing the treatment and recovery needs of Jefferson County and developed a strategic, workforce, and sustainability plan.

Telehealth Related Projects

MAT telehealth | Port Gamble S'Klallam Health Clinic
Port Gamble S'Klallam Health Clinic initiated telehealth services allowing counselors and MAT providers to provide individual and group services via telehealth. Telehealth has been implemented across primary care and behavioral health services.

Virtual dialectical behavior therapy | Kitsap Mental Health Services
Kitsap Mental Health Services implemented virtual Dialectical Behavior Therapy (DBT) within the Child and Family Department. The program has since seen a 100% participation rate.

Community Connect pilot clinic | Jamestown Family Health Clinic
Integration of virtual/telehealth visits and patient scheduling via a patient portal

(MyChart). Jamestown Family Health Clinic was the Community Connect pilot clinic for the implementation and testing of the integrated telemedicine using Zoom with MyChart. This allows a more efficient and functional telemedicine experience for the patient. Medical Laboratory Technicians and Licensed Clinical Social Worker were trained to provide audio/video as well as telephone only visits.

OCH Solutions

In addition to supporting partner projects and initiatives (such as the ones listed above), OCH is committed to leading creative approaches addressing regional health priorities. The examples below outline a few areas that OCH will be taking lead on over the next year.

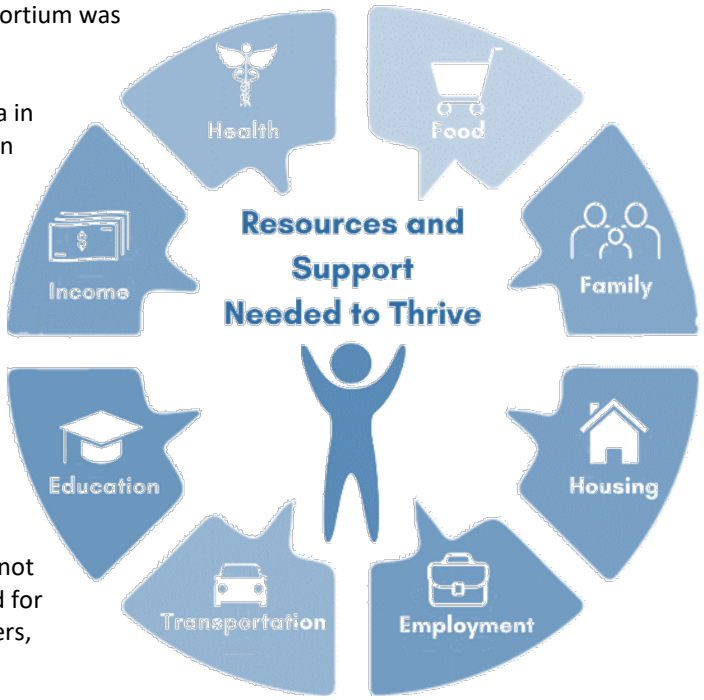
Addressing Stigma

Stigma is defined as "a mark of disgrace associated with a person, a personal quality, or a personal circumstance." [53] Stigma can be a barrier to seeking behavioral health services. It can also be a barrier to reaching out to friends or employers for help as stigma contributes to alienation from others who do not understand the disease or how to help. [54] The American Society of Addiction Medicine webpage reports:

> *"Unfortunately, because of the legal and social ramifications associated with addiction, patients are often reluctant to tell their doctor that they may have addiction or consent to the disclosure of information about their addiction treatment. This is an unfortunate aspect of the stigma that surrounds this disease, and it exacerbates the addiction treatment gap that exists in this country."* [55]

OCH and its partners are committed to addressing stigma in the Olympic region in 2021. The Steering Committee of Three-county Coordinated Opioid Response Project (3CCORP) prioritized stigma as an intervention focus area. OCH was awarded $245,000 by Cambia Health Solutions and directed those funds be used to implement a multi-prong approach to combat behavioral health stigma in our region, especially stigma related to substance use disorder.

At the local level, the Jefferson County Behavioral Health Consortium was awarded $1,000,000 Rural Communities Opioid Response – Implementation (RCORP-I) by Health Resources and Services Administration (HRSA) with an objective to address SUD stigma in Jefferson & Clallam counties in partnership with the Jamestown S'Klallam Tribe. [56]



Clallam Care Connection (3C)

Fragmented care occurs when health care providers and other organizations do not effectively work well together. Providers describe working in silos with systems that are not set-up to support collaborative multidisciplinary coordinated care for high-risk Individuals such as those with serious mental health and/or substance use disorders. This challenge is not unique to the Olympic region, a recent study by Health Affairs reported that, "Compared to physicians in other countries, substantial proportions of U.S. physicians did not routinely receive timely notification or the information needed for managing ongoing care from specialists, after-hours care centers,

emergency departments, or hospitals". [57] One of the most effective methods of improving client outcomes while decreasing costs is care coordination.

Clallam Care Connection (3C) is a pilot project that provides coordinated care to improve the health status of individuals with complex, chronic conditions to deliver a seamless experience of care that is person-centered, cost-effective, addresses social determinants of health, and results in improved health and wellness. Connecting weekly, providers from health, social service and community organizations are breaking the silos and moving towards whole-person care. 3C focuses on serving members of the community who are at risk for or experiencing: debilitating mental health and substance use disorder, repeat 911/emergency department use, risk of suicide, transition out of inpatient services or jail/prison; disjointed or discontinuous care.

3C is in its start-up phase with four organizations currently participating: North Olympic Healthcare Network (NOHN), the Port Angeles Fire Department, Peninsula Behavioral Health, and REdisCOVERY (a team of navigators who work closely with the Port Angeles Police Department to respond to mental health crises in the field). The benefits are already apparent with increased appointment and medication adherence among 3C clients and unnecessary 911 and ED visits prevented. Additionally, 3C team members have the benefit of closed-loop referrals (meaning that the outcome of a referral is known). In the future, 3C will use a shared digital information exchange platform if one becomes available and if the parties agree to pay and participate in its use.

Opportunities & Recommendations

There are many opportunities for legislators, policy makers, health care providers, community-based organizations, social service agencies, Tribal health centers, and communities to prioritize behavioral health. OCH's regional partners recommend the following:

Workforce

- Provide advocacy to increase salaries for behavioral health providers commensurate with their education, training, and the cost-saving benefit their services provide.
- Conduct a behavioral health workforce study to ascertain current strengths and opportunities to address workforce staffing shortages.
- Advocate for behavioral health reimbursement rates that are based on actual costs and salaries, not on past and current rates which have not kept up with cost of living and education.
- Improve access to housing. Ensure that housing (rental and home ownership) is affordable over time for occupancy by local employees and residents.

Determinants of Health

- Prioritize innovative and creative housing and transportation solutions to improve access to care across the region.
- Strengthen partnerships between community-based organizations and clinical providers to address social needs.
- Sustainable funding to address determinants of health.

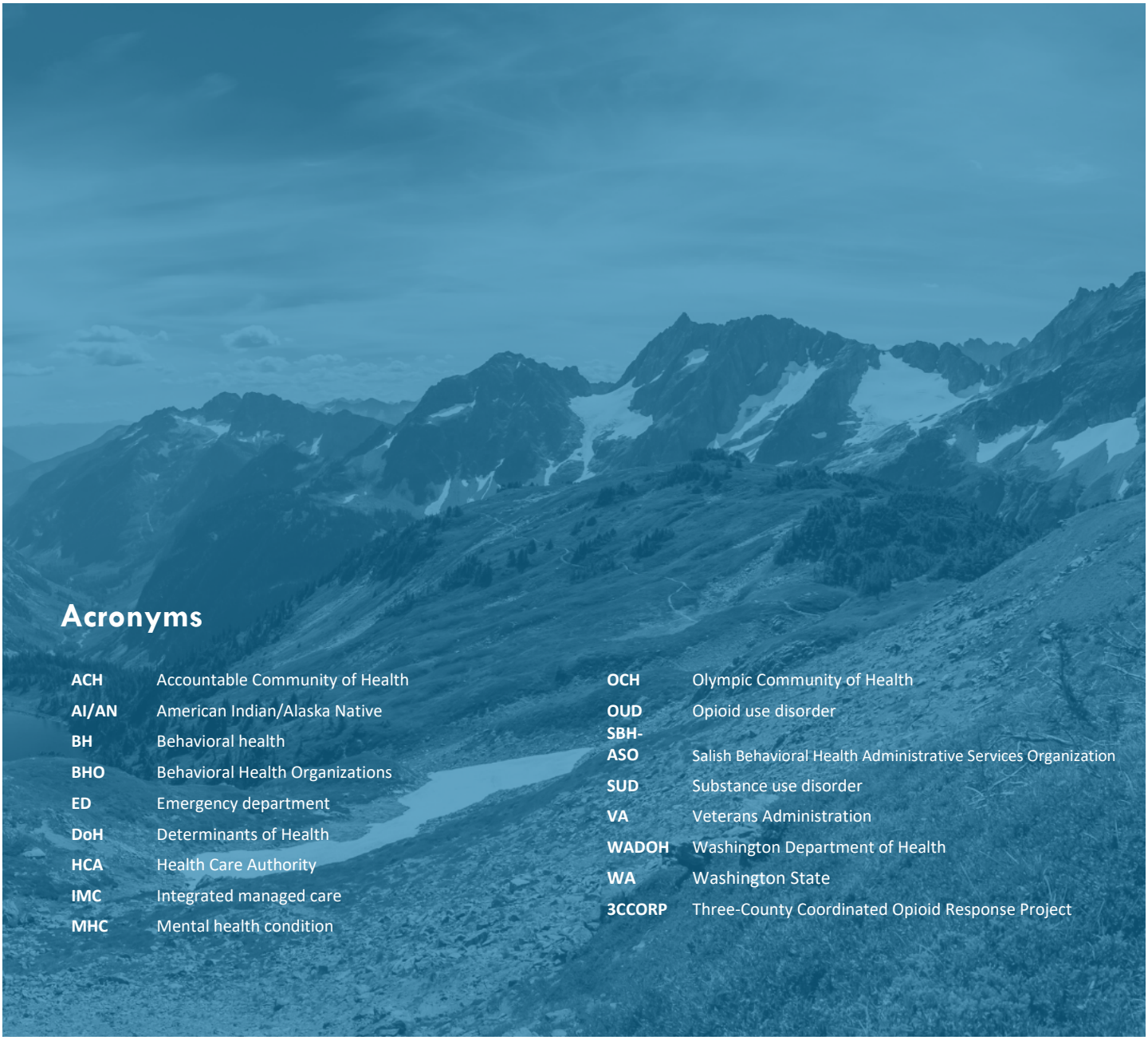
Services

- Address the need for additional withdrawal management and stabilization services in the Olympic region and across the state.
- Implement guidance that improves data sharing and communication between clinical and community partners.
- Increase mental health and substance use disorder services; expand eligibility for existing services and increase the number and type of services.

- Increase funding to the Behavioral Health Administrative Service Organizations to funding levels of 2018 and 2019. This will improve access to non-crisis services, such as outpatient treatment, among non-Medicaid individuals.

Technology & Whole Person Care

- Establish guidance to streamline and support implementation of HIE in our region and state. Enhance referral systems and processes to better connect clients to existing community resources.
- Address perceived barriers to coordination and integration of care, including health information exchanges (HIE) among behavioral health providers regionally and statewide. Provide training on complying with confidentiality regulations such as 42CFR Part 2 while using HIE.
- Continue to support COVID-19 recovery and resources including cell phones and laptop distribution programs for Medicaid clients to ensure continued access to services and treatment.



Acronyms

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
BH	Behavioral health
BHO	Behavioral Health Organizations
ED	Emergency department
DoH	Determinants of Health
HCA	Health Care Authority
IMC	Integrated managed care
MHC	Mental health condition
OCH	Olympic Community of Health
OUD	Opioid use disorder
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance use disorder
VA	Veterans Administration
WADOH	Washington Department of Health
WA	Washington State
3CCORP	Three-County Coordinated Opioid Response Project

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